State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

DATE: April 3, 2007

TO: INTERESTED PARTIES

SUBJECT: OPEN APPLICATION PERIOD FOR GEOGRAPHIC MANAGED CARE IN SACRAMENTO COUNTY AND MANAGED CARE EXPANSION INTO PLACER COUNTY

The California Department of Health Services (CDHS) Medi-Cal Managed Care Division will initiate an open application period for any health care plans interested in applying to participate in the existing Sacramento County Geographic Managed Care (GMC) model and will simultaneously conduct an open application period to expand Medi-Cal managed care into Placer County. This letter is to solicit applications from qualifying health care plans that are interested in providing health care to Medi-Cal eligible individuals residing in Sacramento County and/or Placer County.

The goal of the Medi-Cal managed care program is to provide access to quality health care for Medi-Cal beneficiaries in an organized and cost-effective system of care. Under the Medi-Cal Managed Care program, certain beneficiaries are required to enroll in State contracted health care service plans and select a primary care physician to provide, through an ongoing patient-physician relationship, primary care services and referrals for necessary specialty care. Non-mandatory Medi-Cal beneficiaries may voluntarily enroll in these plans or remain in the fee-for-service Medi-Cal delivery system.

The Sacramento GMC model, operational since April 1994, currently includes six Knox-Keene licensed health care service plans under contract with CDHS. The rates, terms, and conditions of these contracts are negotiated by the California Medical Assistance Commission (CMAC) on behalf of CDHS.

Prospective health care service plans who are interested in participating in the Request for Application (RFA) process are required to submit a Letter of Intent on their plan's letterhead indicating the intent to submit an application to provide health care services for Medi-Cal beneficiaries in Sacramento County and/or Placer County. The Letter of Intent must contain the following:

- The plan's statement that it is interested in participating in this RFA process by identifying which of the above-mentioned counties for which it is applying;
- The legal health plan name and complete address;

- Name and title of the person who can legally bind the plan;
- Name, title, address, telephone number, electronic mail address, and facsimile number of the person to whom all communication regarding this program should be addressed; and
- Current Knox Keene License status.

The Letter of Intent must be postmarked no later than 4 p.m. on April 23, 2007, and mailed via express mail. Hand delivery, facsimile, and e-mailed Letters of Intent will not be accepted. Plans not responding via the method identified above, by the required date and time will not be permitted to participate in this RFA process. Letters of Intent should be labeled and addressed as follows:

Vivian Auble, Chief
Plan Management Branch
Medi-Cal Managed Care Division
California Department of Health Services
1501 Capitol Avenue
P.O. Box 997413, MS 4407
Sacramento, CA 95899-7413

Enclosed is a copy of the RFA to facilitate your response, should you decide to participate in this process. Please refer to the enclosed RFA for a complete list of required information. Each item must be identified by an item number, (e.g., 1 through 16). Applicants must submit three complete sets of application information. Pursuant to state law, interested health care service plans must demonstrate an ability to meet program standards. The GMC health plan contract specifies required program standards. Applicants may contact CMAC at (916) 324-2726, for a copy of the GMC contract. CDHS will evaluate completed applications submitted timely to determine the applicant's financial, organizational, administrative, operational and health care delivery capabilities. If approved, the applicant will be referred to CMAC to begin negotiation of the contract terms, and conditions for the selected county(ies).

In addition to the Letter of Intent submission requirements, all applicants must submit RFA application materials (the basic requirements submitted in the required format) to CDHS by 4 p.m. on May 7, 2007, to the CDHS address indicated above. Plans not responding by this time and date will not be allowed to participate in this RFA selection process. The CDHS will not review late applications.

CDHS reserves the right to terminate this RFA process in part or in its entirety for any reason if the CDHS determines that termination is in the best interest of the State or its beneficiaries. The CDHS shall give notification at least 30 days prior to the effective date of termination.

If you have any questions, please contact Mr. Willie Anderson, Chief of the County Organized Health Systems, GMC, and Other Contracts Section at (916) 449-5078.

Sincerely,

Original signed by *Vanessa M. Baird*

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Enclosure

cc: Mr. Keith Berger, Executive Director
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL MANAGED CARE DIVISION

REDESIGN AND EXPANSION UNIT

REQUEST FOR APPLICATION

NUMBER 07-042007

APRIL 3, 2007

(This RFA is also available in electronic form on the Internet at the California Department of Health Services/Office of Medi-Cal Procurement website at www.dhs.ca.gov/omcp)

RFA DIRECTORY

PROJECT DESCRIPTION	PAGE 3
REQUIRED CONTENT OF APPLICATION	PAGE 5
BASIC REQUIREMENTS	PAGE 6
APPLICATION SUBMISSION REQUIREMENTS	PAGE 10
DELIVERABLES	PAGE 11
QUESTIONS REGARDING THIS RFA	PAGE 28
CDHS/MMCD DISCLAIMER	PAGE 29

ATTACHMENTS

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
MEDI-CAL MANAGED CARE DIVISION
REDESIGN and EXPANSION SECTION
REQUEST FOR APPLICATION
FISCAL YEAR 2007-2008

A. PROJECT DESCRIPTION

The California Department of Health Services (CDHS), Medi-Cal Managed Care Division, in conjunction with the California Medical Assistance Commission (CMAC), seeks interested, qualified health care plans to participate in the Sacramento County Geographic Managed Care (GMC) program and a newly created Placer County GMC program. An applicant may apply to participate in one county, or both counties. The CDHS will refer qualifying applicants to CMAC to negotiate a GMC contract. Qualifying applicants who enter into contracts and meet all contractual implementation requirements would provide health care services to Medi-Cal beneficiaries.

CDHS is the single State agency responsible for administration and oversight of the Medi-Cal program. The goal of the managed care program is to provide access to quality health care for Medi-Cal beneficiaries in an organized and cost effective system of care. The GMC program is operated in accordance with the State Medicaid Plan and applicable state and federal statutes and regulations, including Welfare & Institutions Code Section 14089 and Title 22, California Code of Regulations, Section 53900, et. seq. Under the GMC program, certain beneficiaries must enroll in State contracted health care service plans and select a primary physician to provide, through an ongoing patient-physician relationship, primary care services and referrals for necessary specialty care. Non-mandatory Medi-Cal beneficiaries may voluntarily enroll in these plans or remain in the fee-for-service Medi-Cal delivery system.

To participate in the GMC program, a health care plan must be licensed under the Knox-Keene Health Care Service Plan Act of 1975 prior to commencing operations as a GMC contractor. The Sacramento GMC program, operational since April 1994, currently includes six Knox-Keene licensed health care service plans under contract with CDHS. These contracts are set to expire in or about December 2007. At the present time, Placer County is not a managed care county; and FFS is the only delivery system for Medi-Cal. Although CDHS administers the GMC contracts, CMAC negotiates the rates, terms and conditions of GMC contracts, with contractors being paid on a per member, per month capitation basis. Qualifying applicants under this Request for Application (RFA) are not guaranteed a GMC contract; rather, they will be referred to CMAC for contract negotiations.

B. TENTATIVE TIMELINE

RFA Release	April 3, 2007
Letter of Intent Submission Deadline	April 23, 2007
Deadline for Submitting Written Questions and Seeking Clarification	May 30, 2007
Questions (if any) and Responses Sent from MMCD to Applicant	June 18, 2007
Application Submission Deadline	May 7, 2007
Release of Notice of Intent to Award	October 30, 2007
Tentative Date for Commencement of Contract Operations	January 1, 2008

C. FUNDING AVAILABILITY/CONTRACT TERM

To participate in the GMC program, a qualifying applicant must negotiate a contract with CMAC. It is anticipated that the Operations Period of the contract—the period during which services are provided to Medi-Cal beneficiaries and capitation payments are made to the contractor—would commence in or about January 2008, and would be for a three year term (including options), or such longer period as the parties agree to and the law permits. The contractor would assume the total risk of providing covered services in exchange for the periodic capitation payment for each beneficiary, unless otherwise agreed in the contract. Any monies received but not expended by the contractor after having fulfilled obligations under the contract would be retained by the contractor.

Payment under the contract is subject to the availability of State general funds and federal financial participation. If full funding is not available, the State may cancel the contract or offer a contract amendment to reflect the reduced amount.

D. LETTER OF INTENT

Prospective health care service plans that are interested in participating in this RFA must submit a Letter of Intent on plan letterhead indicating an intent to submit an application to provide health care services for Medi-Cal beneficiaries in Sacramento County and/or Placer County. The Letter of Intent must contain the following:

- The Plan's statement that it is interested in participating in this RFA process by identifying which of the above-mentioned counties for which it is applying;

- The legal health plan name and complete address;

- Name and title of the person who can legally bind the plan;

- Name, title, address, telephone number, electronic mail address, and facsimile number of the person to whom all communication regarding this program should be addressed; and

- Current Knox-Keene License status.

The Letter of Intent must be received no later than 4 p.m. on April 23, 2007, and mailed via express mail or delivered by courier. Hand delivery, facsimile, and e-mailed Letters of Intent will not be accepted. Plans not responding via the method identified above, by the required date and time will not be permitted to participate in this RFA process. Letters of Intent should be labeled and addressed as follows:

Vivian Auble, Chief
Plan Management Branch
Medi-Cal Managed Care Division
California Department of Health Services
1501 Capitol Avenue, MS 4407
Sacramento, CA 95899-7413

E. APPLICATION FORMAT AND CONTENT

1. REQUIRED CONTENT OF APPLICATION

The following is the order in which applicants must submit sections in the application; a brief description of each section to be included is given below.

a) Signed Transmittal Letter

The transmittal letter required in this application must be on the official business letterhead of the Applicant and signed by the individual authorized to bind the Applicant legally in contractual agreements.

b) Table of Contents

Within the Table of Contents, each Section, Subsection, Response, and Attachment must be clearly identified, and page numbers (or tab numbers) given to each item.

c) Executive Summary

The Executive Summary provides an overview of the Applicant's organization and a summary of the application, including designation of the county or counties for which the Applicant is applying to provide services. The summary must provide a description of the organization and operation of the Applicant's business as a health care service plan, covering the highlights and essential features of the information provided in response to this application.

d) Responses to GMC Program RFA Basic Requirements

Applicants must respond to all of the GMC Program basic requirements as set forth in subsection E 2 below. The responses must be complete and arranged in sequential order and each response must be numbered with the corresponding number assigned to each section, sub-section, requirement, and item. Tabs must separate and identify each response item.

e) Application Attachments

The application must contain a list of all attachments submitted by the Applicant. Each attachment must be clearly identified with the section, requirement, and item to which it applies, followed by a dash and number in sequence. The attachment must be included at the end of the subsection in which the submission requirement is contained.

2. BASIC REQUIREMENTS

As part of its application, each applicant must provide the basic requirements set forth in this subsection (Basic Requirements). Only those applicants that satisfy the Basic Requirements will be deemed qualifying applicants. The Basic Requirements are part of the GMC program standards. GMC program standards are specified in the GMC boilerplate contract, and applicants can obtain a copy from CMAC by calling (916) 324-2726. CDHS will evaluate completed applications submitted timely and in accordance with all submission requirements of this RFA to determine the applicant's financial, organizational, administrative, operational and health care delivery capabilities. If approved, the CDHS will refer the applicant to CMAC to begin contract negotiations. Referral to CMAC does not guarantee that the qualifying applicant will receive a Medi-Cal contract.

Basic Requirements:

Each of the Basic Requirements listed below must be met prior to being referred to CMAC. Please review and provide CDHS with the Basic Requirements as indicated below (Please label boxes and binders containing Basic Requirements information).

1) A brief history and general description of the organization.

2) A description of the proposed or existing administrative structure including:

   a. The functions and responsibilities of all principals, policymakers, administrator, medical director and other executive officers.

   b. An organization chart and functional description of each organizational unit.

3) A list of all principals, policymakers, executive officers, providers of health care services and other key personnel, including the following information:

   a. Full name;

   b. Business address;

   c. Date and place of birth;

   d. Internal Revenue Service employer number, when applicable; and

   e. License number, medical specialty and Medi-Cal provider number when applicable.

4) Copy of a current Knox-Keene license or a license application.

   If not currently licensed to operate in the geographical area applied for in this application, the applicant must submit a complete material modification to operate to the Department of Managed Health Care (DMHC) within 30 working days of CDHS referral to CMAC. Applicants must submit a copy of the material modification to CDHS concurrently. Contract operations shall not begin until the DMHC approves the material modification and CDHS approves all contract implementation deliverables and requirements.

5) Financial information including:

   a. A detailed cash flow budget, including all written assumptions, estimates and projections, demonstrating the availability and sources of funds to meet the obligations under the contract, for the prospective contract period. Supporting budgets for such affiliates must be provided when the applicant relies upon affiliates to provide services under the contract (see Title 22, Section 53102 of the California Code of Regulations for the definition of “affiliate”);

b. A projected calculation of Tangible Net Equity (TNE). The GMC program requires a contractor to be at all times in compliance with the TNE requirements of Title 28, the California Code of Regulation Section 1300.76.; and

c. Certified financial statements, presented on a combined basis with all affiliates, as of the applicant's fiscal or calendar-year end. No additional disclosures are required when the contractor's submission is within 90 days after the end of the applicant's fiscal year. Unaudited financial statements to the most current quarter end shall also be submitted if the applicant's submission occurs prior to or more than 90 days after the close of the applicant's fiscal year. Unaudited statements shall be prepared on a combined basis.

6) A description of the proposed or existing health care delivery system, including information concerning the following:

a. The scope and availability of services to be provided under the proposed contract including core specialties and ancillary services;

b. The ratios of all physicians to the prepaid patient population and specifically primary care physicians to the prepaid patient population (At a minimum, one primary care provider to each 2,000 enrollees.);

c. Location and description of all service sites, including but not limited to: hospitals, pharmacies, laboratory and X-ray facilities, and skilled nursing facilities, with information about the service availability at each location;

Applicants must submit a Geo Access report using data for all eligible beneficiaries (both voluntary and mandatory populations [http://www.dhs.ca.gov/mcss/default.htm]) and must include the following in an accessibility summary:

- number of providers;
- number of members;
- access standard used;
- percentage of members who meet the standard;
- average distance to a choice of providers for all members (within 30 minutes or 10 miles from residence or workplace);
- key geographic areas broken down by city; and

- A delineation of the zip codes of the proposed or existing contract service area and the location of the Medi-Cal beneficiary target population within the services area.

Include the following information:

- Zip code access standard detail information;
- Zip codes meeting the access standard;
- Zip codes not meeting the access standard; and
- Zip code radius information, which identifies the number of providers within certain mileage designations.

d. The availability of services in emergency circumstances; and

e. The medical record and medical record service system to be used by the plan, including procedures for appropriate handling and maintenance of medical records regardless of form (electronic, paper, etc.).

7) A description of proposed marketing efforts, with realistic enrollment and marketing cost projections, for both Medi-Cal and private target population enrollment.

8) Copies of all proposed or existing subcontracts related to securing health care services, administrative and management services or any other services necessary to fulfill contractual obligations.

9) Applicants must either achieve actual Disabled Veteran Business Enterprise (DVBE) participation or make an adequate Good Faith Effort (GFE) to meet the DVBE participation requirements. Detailed requirements are outlined in Attachment 1 (DVBE Instructions/Forms). Random verification will be conducted for applicants who have satisfied DVBE requirements using the GFE process.

10) A description of the proposed or existing system for promptly reimbursing non-plan providers for emergency services rendered to members.

11) Certification of willingness and ability to enroll members regardless of their race, creed, color, religion, age, sex, national origin, sexual orientation, marital status or ancestry; and without reference to preexisting medical conditions other than those specifically excluded from coverage under the contract.

12) A proposed description of procedures to be sent to members that will describe how grievances are processed and resolved.

13) Certification of Health Insurance Portability and Accountability Act (HIPAA) compliance and evidence/method of patient notification of HIPAA confidentiality and Notice of Privacy Practices distribution. Also, the ability to provide HIPAA training for new staff and proof of training for existing staff.

14) A description of the proposed or existing procedures for ensuring requests for services submitted on behalf of a beneficiary by a provider (Prior Authorization Requests) are handled in accordance with the time frames and notice requirements set forth in the GMC boiler plate contract.

F. APPLICATION SUBMISSION REQUIREMENTS

Applicants must submit applications and all clarifications/responses in 12-point font, on three-hole punched 8 1/2" x 11" white bond paper, with pages numbered sequentially and bound in three ring binders. Certain forms and statements in the application shall require signatures.

Submit one (1) original and two (2) copies, and one (1) CD-ROM of the application. Label the original hard copy “Original” and number each copy. Label the CD-ROM “GMC RFA 2007.”

The original application shall contain original signatures. The copies of the application shall contain a photocopy of the signatures. All copies shall include the typewritten name and position of the person signing. The application must be submitted in full sets (i.e., application volumes 1 through 15 are packed together, rather than having one package containing three (3) issues of volume 1). One (1) complete set of the application (the original) shall be designated as the "master set" and the box shall be labeled as such. The outside of each box containing a full set of responses must be identified as box 1 of 12, box 2 of 12, etc., and marked with the name of the Applicant and the statement: Application Response to Sacramento/Placer GMC Program.

Boxes are not to exceed the dimensions of 18" x 12" x 12" with a weight of no more than forty (40) pounds each. CDHS will not accept boxes exceeding these dimensions. CDHS will only accept applications by personal delivery to the GMC Program between the hours of 8 a.m. and 4 p.m.

All applications must be addressed and submitted to:

Jeff Kemp
Expansion and Redesign Section
Medi-Cal Managed Care Division
California Department of Health Services
1501 Capitol Avenue, MS 4416
Sacramento, CA 95899-7413

The application must be submitted to CDHS by 4 p.m. on May 7, 2007. Applications submitted via hand delivery to the above-mentioned address must stop at the guard desk. Please request the guards to contact J. J. Woods in the Expansion/Redesign Unit at (916) 552-9803, or Debra Mullins at (916) 449-5144, both of whom who are authorized to accept the applications. Late applications will be deemed non-responsive and will not be reviewed. Applicants are responsible for all costs of developing and submitting an application.

An application must be complete when submitted to CDHS. An entire application may be withdrawn and a new application submitted, provided the withdrawal and resubmission are completed by the application submission deadline. The resubmission must meet all of the application submission instructions. Withdrawal may be accomplished by providing CDHS a written withdrawal request signed by an authorized representative of the applicant on plan letterhead.

G. DELIVERABLES

Once CDHS has referred a qualifying applicant to CMAC for contract negotiation, the qualifying applicant will have 15 calendar days to submit a work plan(s) that describes in detail how and when it will complete and submit to CDHS the deliverables set forth in this section. The qualifying applicant's work plan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency arrangements in the event of operational delays.

The work plan(s) shall identify all of the deliverables, milestones and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. In some instances, a deliverable specifically refers to a provision in the GMC boilerplate contract, which correlates to the deliverable. However, the deliverables in this section do not refer to all standards in the GMC boilerplate contract that are or may be applicable. To assist in preparation of its work plan(s) and submission of deliverables, a qualifying applicant may obtain a copy of the GMC boilerplate contract from CMAC by calling (916) 324-2726.

All work plans are subject to CDHS review and approval; however, a qualifying applicant should not delay submission of deliverables pending that approval.

Rather, qualifying applicants should begin the submission of deliverables while waiting for CDHS approval. It is anticipated that submission, review and approval of work plan(s) and deliverables could take a total of six to nine months. Submission of the work plans(s) and deliverables does not guarantee a qualifying applicant a contract, which must be negotiated with CMAC.

If the qualifying applicant successfully negotiates a contract with CMAC and this RFA omits a deliverable required by the contract, contractor will be required to comply with all contract requirements including submission of all deliverables required by the contract. Further, if any inconsistency or conflict occurs between the contract and this RFA, the contract will be deemed to control.

The list of deliverables is as follows:

Please identify the county(ies) for which you are applying to provide services and provide a complete set of deliverables for each. (Please circle a minimum of one):

Placer	Sacramento

1. Organization and Administration of the Plan

a. Submit documentation of any employees (current and former State employees) who may have a conflict of interest if applicant contracts with CDHS;

b. Submit a complete organizational chart; and

c. Submit the following Knox-Keene license exhibits and forms found in Title 28, CCR, Section 1300.51 et.seq., reflecting current operation status:

1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.

i. Corporation: Exhibits F-1-a-i through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A.

ii. Partnership: Exhibits F-1-b-i and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B.

iii. Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C.

iv. Other Organization: Exhibits F-1-d and F-1-d-ii, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships, Form HP 1300.51-D.

v. Public Agency: Exhibits F-1-e-i through F-1-e-iii.
Title 28, CCR, Section 1300.51(d)F1a-e

2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above.
Title 28, CCR, Section 1300.51(d)F1f

3) Exhibits F-2-a and F-2-b: contracts with Affiliated Persons, Principal Creditors and Providers of Administrative Services.
Title 28, CCR, Section 1300.51 (d) F2

4) Exhibit F-3 Other Controlling Persons.
Title 28, CCR, Section 1300.51(d)F3

5) In addition to Exhibits F, shall demonstrate compliance with requirements of Title 22, CCR, Sections 53874 and 53600. Identify any individual named in this item b. that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.

d. Submit Exhibits N-1 and N-2: Contracts for Administrative Services. Title 28, CCR, Section 1300.51(d) N1&2

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

a. Submit most recent audited annual financial reports.

Exhibit GG-1-a

Title 28, CCR, Section 1300.51(d) (GG)

b. Submit quarterly financial statements with the most recent quarter prior to execution of the Contract.

Exhibit GG-1-b

Title 28, CCR, Section 1300.51(d) (GG)

c. Submit the following Knox-Keene license exhibits reflecting projected financial viability:

   1) Exhibit HH-1;

   2) Exhibit HH-2
      Title 28, CCR, Sections 1300.51(d)HH and 1300.76; and

   3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative member months for quarterly financial projections.

d. Submit Knox-Keene license Exhibit HH-6. Include the following:

   1) Exhibit HH-6-a

   2) Exhibit HH-6-b

   3) Exhibit HH-6-c

   4) Exhibit HH-6-d

   5) Exhibit HH-6-e

   Title 28, CCR, Section 1300.51(d)HH

e. Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with CDHS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this RFA. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22, CCR, Sections 53863 and 53868;

f. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:

   1) Exhibit II-1

   2) Exhibit II-2

   3) Exhibit II-3

   Title 28, CCR, Section 1300.51(d)II

g. Describe systems for ensuring that subcontractors, who are anticipated would be at risk for providing services to Medi-Cal members, as well as any obligations or requirements delegated pursuant to a subcontract, have the administrative and financial capacity to meet their contractual obligations;

   Title 28, CCR Section 1300.70(b)(2)(H)1

h. Submit financial policies that relate to applicant's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures;

i. Submit policies and procedures for a system to evaluate and monitor the financial viability of all proposed subcontracting entities.

3. Management Information System

The purpose of this section is for the applicant to demonstrate, through a well-documented submission, that it has a sufficient management information system (MIS), the expertise to undertake the Medi-Cal contract, and the ability to conform to the Federal Health Insurance Portability and Accountability Act of 1996.

A Contractor will be required to collect and provide encounter data. This data will be combined with other service data covered outside of the Contractor's contract and will be utilized by CDHS for the following purposes: to evaluate health care quality and cost containment performance, to evaluate contractual performance, to develop and evaluate proposed or existing capitation rates, and for CDHS to meet the Medicaid reporting requirements for claims and encounters.

An encounter is defined as a medically related service, drug or supply rendered by medical providers to a Medi-Cal beneficiary who is an active member of a contracted managed care plan on the date of service. It applies to all services for which the managed care plan is capitated. An encounter record is either (1) an accounting of the delivery of a specific medical service(s) for which the managed care plan has a capitated or other financial arrangement with a provider (shadow claim), or (2) an encounter for which the managed care plan has processed a claim. The record of the encounter includes all the diagnoses made, procedures performed by that individual health care provider. The encounter data elements are designed to capture all service data at the lowest level of delivery of the medical service.

There are four record formats that reflect the type of medical service normally reported on the HCFA-1500, UB-92, and Universal Drug claim forms. These record formats are Inpatient, Pharmacy, Long Term Care and Outpatient. The

outpatient format includes services for vision, dental, ancillary and all other medical outpatient services.

CDHS' review of the Applicant's MIS for this section relates to the intake, flow and use of data within the Plan, as well as submission of encounter data to the Department. This documentation must provide assurance that the Applicant has the capability to capture and utilize various data elements for its internal management and to meet the requirements of CDHS.

The CDHS will assess and evaluate the applicant's ability to meet the contractual requirements contained in this section, against the "Model MIS Guidelines" (Attachment 2), the Managed Care Organization (MCO) Baseline Assessment Information System Capabilities.

The technical requirements for the submission of encounter data to CDHS are found in the Managed Care Encounter Data Dictionary/Manual and the Medi-Cal Extranet for State Health Care (MESH) User Manual.

The applicant must submit the following:

a. A completed MCO Baseline Assessment Form (Attachment 3).

b. If procuring a new MIS or modifying a current system, Applicant shall provide a detailed implementation plan that includes:

    1) Outline of the tasks required.

    2) The major milestones.

    3) The responsible party for all related tasks.

    4) A full description of the acquisition of software and hardware, including the schedule for implementation.

    5) Full documentation of support for software and hardware by the manufacturer or other contracted party.

    6) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results.

    7) Documentation of system changes related to the HIPAA of 1996 requirements.

c. Submit a detailed description of how Applicant will monitor the flow of encounter data from provider level to the organization.

d. Submit Encounter data test produced from real or dummy data processed by the MIS. Monthly encounter submissions may not take place until this test has been successfully completed.

e. Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.

f. Submit a work plan for compliance with the HIPAA of 1996.

g. Submit the data security, backup, recovery, or other disaster processes used in the event of a MIS failure.

h. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems:

    1) Financial

    2) Member/Eligibility

    3) Provider

    4) Encounter/Claims

    5) Quality Management/Utilization

i. Submit a sample and description of the following reports generated by the MIS:

    1) Member Roster

    2) Provider Listing

    3) Capitation Payments

    4) Cost and Utilization

    5) System Edits/Audits

    6) Claims Payment Status/Processing

    7) Quality Assurance

    8) Utilization

    9) Monitoring of Complaints

4. Quality Improvement System (QIS)

a. Submit a written description of the QIS, including:

   1) A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.

   2) A description of the responsibility of the Governing Body in the QIS.

   3) A description of the QI Committee, including membership, activities, roles and responsibilities.

   4) A description of how providers will be kept informed of the written QIS, its activities and outcomes.

   5) A description of how the Plan reports any disease or condition to public health authorities as required by State law or regulation.

b. Policies and procedures related to the delegation of the QIS activities.

c. Boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.

d. Policies and procedures to address how the Applicant will meet the following requirements:

   1) External Accountability Set (EAS) Performance Measures;

   2) Quality Improvement Projects;

   3) Consumer Satisfaction Survey.

e. Policies and procedures for performance of Primary Care Provider site reviews.

f. A list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.

g. The aggregate results of pre-operational, existing or in expanded areas, site review to CDHS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by CDHS.

h. Policies and procedures for credentialing and re-credentialing.

5. Utilization Management

a. Submit a written description of Applicant's Utilization Management (UM) program that describes appropriate processes it will use to review and approve the provision of medical services including:

   1) Procedures for pre-authorization, concurrent review, and retrospective review.

   2) A list of services requiring prior authorization and the utilization review criteria.

   3) Procedures for the utilization review appeals process for providers and members.

   4) Procedures that specify timeframes for medical authorization.

   5) Procedures to detect both under- and over-utilization of health care services.

b. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.

6. Provider Network

a. Submit a complete provider network that is adequate to provide required covered services for members in the selected service area.

b. Submit policies and procedures describing how applicant will monitor provider to patient ratios to ensure they are within specified standards as specified in Exhibit A, Attachment 6, provision 2, of the GMC boiler plate contract.

c. Submit policies and procedures regarding physician supervision of non-physician medical practitioners.

d. Submit a complete list of specialists by type within the applicant's network.

e. Submit policies and procedures for how applicant will meet Federal requirements for access and reimbursement for in-Plan and/or out-of-Plan Federally Qualified Health Centers services consistent with Exhibit A, Attachment 6, of the GMC boilerplate contract.

f. Submit a policy regarding the availability of a health plan or contracting physician 24 hours a day, 7-days a week, and procedures for communicating with emergency room personnel.

g. Submit a report containing the names of all subcontracting provider groups.

h. Submit an analysis demonstrating the ability of the applicant's proposed provider network to meet the ethnic, cultural, and linguistic needs of the members.

i. Submit all boilerplate subcontracts, signature pages of all subcontracts, and reimbursement rates. CDHS will maintain the confidentiality of the rates to the extent of state law.

j. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.

k. Submit a draft copy of the provider directory.

l. Submit a Geo Access report or similar showing that the proposed provider network meets the time and distance standards set forth in Exhibit A, Attachment 6, provision 7, of the GMC boilerplate contract.

7. Provider Relations

Submit policies and procedures for handling provider grievances.

a. Submit protocols for payment and communication with non-contracting providers.

b. Submit a copy of the provider manual.

c. Submit a schedule of provider training to be conducted during year one of the operation. Include the date, time and location, and a complete curriculum.

8. Provider Compensation Arrangements

a. Submit a description of any physician incentive plans.

b. Submit policies and procedures for processing and payment of claims.

c. Submit excerpt from the provider manual that describes the prohibition of a claim or demand reimbursement for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.

d. Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).

e. Submit schedule of per diem rates and/or fee-for-service rates for each of the following provider types:

   1) Primary Care Providers

   2) Medical Groups and Independent Practice Associations

   3) Specialists

   4) Hospitals

   5) Pharmacies

9. Access and Availability

a. Submit policies and procedures that include standards for:

   1) Appointment scheduling

   2) Routine specialty referral

   3) First prenatal visit

   4) Waiting times

   5) Urgent care

   6) After-hours calls

   7) Unusual specialty services

Applicant's policies and procedures must meet or exceed the standards set forth in Exhibit A, Attachment 9, provision 3, of the GMC boilerplate contract.

b. Submit policies and procedures for the timely referral and coordination of any Covered Service to which the applicant would have objections to perform or otherwise support.

c. Submit policies and procedures for standing referrals.

d. Submit policies and procedures regarding 24-hour/day access without prior authorization, follow-up and coordination of emergency care services.

e. Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.

f. Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

g. Submit policies and procedures regarding applicant and subcontractor compliance with the Civil Rights Act of 1964.

h. Submit a written description of the Cultural and Linguistic Services Program required by Exhibit A, Attachment 9, provision 12, of the GMC boilerplate contract. Include policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors as well as policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.

i. Submit a timeline and work plan for the development and performance of a group needs assessment.

j. Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

k. Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how the Applicant will ensure that the CAC will be involved in appropriate policy decisions.

10. Scope of Services

Submit the following consistent with the requirements of Exhibit A, Attachment 10, of the GMC boilerplate contract.

a. Submit policies and procedures for providing:

   1) Initial Health Assessments (IHA)

   2) The Individual Health Education Behavioral Assessment (IHEBA).

b. Submit policies and procedures, including standards, for the provision of the following services for members under twenty-one (21) years of age:

   1) Children’s preventive services

   2) Immunizations

   3) Blood lead screens

4) Screening for Chlamydia

5) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services

c. Submit policies and procedures for the provision of adult (21 years and older) preventive services, including immunization.

d. Submit policies and procedures for the provision of services to pregnant members, which include the following:

1) Prenatal care

2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines

3) Comprehensive risk assessment tool for all pregnant women

4) Referral to specialists

e. Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.

f. Submit health education policies and procedures which include:

1) Administration and Oversight of the Health Education System

2) Delivery of Health Education Programs, Services and Resources

3) Evaluation and Monitoring of the Health Education System

g. Provide a list and schedule of all health education classes and/or programs that are offered by the plan, either directly or by subcontract.

h. Submit policies and procedures for the provision of:

1) Hospice care

2) Vision care – lenses

3) Mental health services

4) Tuberculosis services

i. Submit standards and guidelines for the provision of Pharmaceutical services and prescribed drugs.

j. Submit a complete drug formulary.

k. Submit a process for review of the drug formulary.

l. Submit policies and procedures for conducting drug utilization reviews.

11. Case Management and Coordination of Care

a. Submit procedures for monitoring the coordination of care provided to members.

   For the remaining items (b. - u.), if these items are included in the provider manual submitted under item 7.c., provide a table/list of where each of the items can be found in the manual. If they are not, submit each item as listed below and include a description of how the Applicant would communicate them to the network providers.

b. Submit policies and procedures for coordinating care of members who also receive services from a targeted case management provider.

c. Submit policies and procedures for the referral of members under the age of 21 years that require case management services.

d. Submit policies and procedures for a disease management program. Include policies and procedures for identification and referrals of members eligible to participate in the disease management program.

e. Submit policies and procedures for referral and coordination of care for members in need of Specialty Mental Health Services from the local Medi-Cal mental health plan or other community resources.

f. Submit policies and procedures for resolving disputes with the local mental health plan.

g. Submit policies and procedures for identification, referral and coordination of care for members requiring alcohol or substance abuse treatment services from both within and, if necessary, outside the applicant's proposed service area.

h. Submit a detailed description of applicant's program for Children with Special Health Care Needs (CSHCN).

i. Submit policies and procedures for identifying and referring children with California Children Services (CCS)-eligible conditions to the local CCS program.

j. Submit policies and procedures for the identification, referral and coordination of care for members with developmental disabilities in need of non-medical services from the local Regional Center and the Department of Developmental Services administered Home and Community Based Waiver program.

k. Submit policies and procedures for the identification, referral and coordination of care for members at risk of developmental delay and eligible to receive services from the local Early Start program.

l. Submit policies and procedures for case management coordination of care for Local Education Agency services, including primary care physician involvement in the development of the member's Individual Education Plan or Individual Family Service Plan.

m. Submit policies and procedures for case management coordination of care of members who receive services through local school districts or school sites.

n. Submit a description of the cooperative arrangement applicant has with the local school districts, including the subcontracts or written protocols/guidelines if applicable.

o. Submit policies and procedures describing the cooperative arrangement that applicant has regarding care for children in Foster Care.

p. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.

q. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.

r. Submit policies and procedures for coordination of care and case management of members with the Local Health Department (LHD) Tuberculosis (TB) Control Officer.

s. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

t. Submit procedures to identify and refer eligible members for Women, Infants, and Children Supplemental Nutrition Program (WIC) services.

u. Submit policies and procedures for the assessment and subsequent disenrollment of members eligible for the following services:

    1) Long-term care

2) Major organ transplants

3) Federal Medicaid Waiver programs

12. Local Health Department Coordination

a. Submit executed subcontracts or documentation substantiating Applicant's efforts to enter into subcontracts with the LHD for the following public health services:

1) Family planning services

2) STD services

3) HIV testing and counseling

4) Immunizations

b. Submit executed subcontracts, memoranda of understanding, or documentation substantiating Applicant's efforts to negotiate an agreement with the following programs or agencies:

1) California Children Services (CCS)

2) Maternal and Child Health

3) Child Health and Disability Prevention Program (CHDP)

4) Tuberculosis Direct Observed Therapy (DOT)

5) Women, Infants, and Children Supplemental Nutrition Program (WIC)

6) Regional centers for services for persons with developmental disabilities.

c. Executed Memorandum of Understanding (MOU) or documentation substantiating Applicant's efforts to negotiate a MOU with the local mental health plan.

13. Member Services

a. Submit policies and procedures that address member's rights and responsibilities. Include method for communicating them to both members and providers.

b. Submit policies addressing member's rights to confidentiality of medical information. Include procedures for release of medical information.

c. Submit policies and procedures for addressing advance directives.

d. Submit policies and procedures for the training of Member Services staff.

e. Submit policies and procedures regarding the development, content and distribution of member information. Address appropriate reading level and translation of materials.

f. Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).

g. Submit policies and procedures for member selection of a primary care physician or non-physician medical practitioner.

h. Submit policies and procedures for member assignment to a primary care physician.

i. Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within 10-days.

j. Submit policies and procedures demonstrating how, upon entry into the applicant's network, the relationship between traditional and safety-net providers and their patients is not disrupted, to the maximum extent possible.

k. Submit policies and procedures for notifying members of denial, deferral, or modification of requests for prior authorization.

14. Member Grievance System

a. Submit policies and procedures relating to Applicant's member grievance system.

b. Submit policies and procedures for Applicant's oversight of the member grievance system for the receipt, processing and distribution, including the expedited review, of grievances. Please include a flow chart to demonstrate the process.

c. Submit format for Quarterly Grievance Log and Report.

15. Marketing

a. Submit applicant's marketing plan, including training program and certification of marketing representatives.

b. Submit copy of the boilerplate request form used to obtain CDHS approval of participation in a marketing event.

16. Enrollments and Disenrollments

a. Submit policies and procedures for how Applicant will update and maintain accurate information on its contracting providers.

b. Submit policies and procedures for how Applicant will access and utilize enrollment data from CDHS.

c. Submit policies and procedures relating to member disenrollment, including, Applicant-initiated disenrollment.

H. QUESTIONS REGARDING THIS RFA

Questions Regarding This RFA or Discovery of Problems or Errors

If, upon reviewing this RFA, a potential applicant has any questions regarding this RFA, discovers any problems, including any ambiguity, conflict, discrepancy, omission, or any other error, the applicant shall immediately notify the Medi-Cal Managed Care Division in writing, to be delivered by express mail, and request clarification or modification of this RFA.

All such inquiries shall identify the author, agency name, address, telephone number, and e-mail address and shall identify the subject in question, specific discrepancy, section and page number, or other information relative to describing the discrepancy.

Questions/Inquiries must be received (only hard copy, express mail accepted) by 5 pm on May 30, 2007. Hand delivered facsimile (FAX), US Postal Service mail, and e-mailed questions/inquiries will not be accepted.

All inquiries are to be labeled and addressed as follows:

EXPRESS MAIL ADDRESS:

California Department of Health Services
Medi-Cal Managed Care Division
Redesign and Expansion Section
1501 Capitol Avenue, MS 4416
Sacramento, CA 95814
Attention: J.J. Woods
RFA #07-042007 Questions

CDHS will mail all submitted questions and the responses to all prospective applicants on June 18, 2007. Specific inquiries determined to be unique to an applicant will be responded to in writing to the requestor only. Applicants that fail to report a suspected or known problem with this RFA or fail to seek clarification

of any perceived ambiguity shall be deemed to have filed their application at their own risk.

The issuance of this RFA does not constitute a commitment by CDHS or CMAC to award a contract or contracts. The CDHS reserves the right to reject any or all applications or terminate this RFA process in part or in its entirety for any reason if the CDHS determines that the termination is in the best interest of the State or its beneficiaries. Notification shall be given at least 30 days prior to the effective date of termination.

I. MISCELLANEOUS PROVISIONS

1. In addition to any condition previously listed in this RFA, the following conditions may cause CDHS to consider an application non-responsive:

    i If the application does not meet all format, content and submission requirements specified in this RFA, including but not limited to the labeling, packaging and/or proper delivery of applications.

    ii If the application is incomplete or contains irregularities of any kind.

    iii If the application contains false or misleading information.

    iv If other irregularities occur in the RFA process that are not specifically addressed herein.

2. By submitting an application, an applicant agrees to authorize CDHS to verify any and all statements made in the application and check any resources available to the State to confirm applicant's business integrity and history of providing timely, effective and efficient services.

3. Up to the application submission deadline, CDHS reserves the right to modify any date appearing in this RFA, issue clarification notices, addenda or alternate RFA instructions, and waive any RFA requirement for all applicants if CDHS deems the requirement to be unnecessary, unreasonable or erroneous.

4. CDHS reserves the right to request an applicant to submit omitted or additional information or documentation before or after the application submission deadline. CDHS will advise the applicant in writing of the information/documentation that is required and the deadline for providing same. Failure to submit the information/documentation to CDHS in a timely manner may be grounds to consider the application non-responsive.

5. The California Public Health Act of 2006 (Act; S. B. 162, Chap. 241, Stats. 2006), effective July 1, 2007, establishes the California Department of Public Health (CDPH) and renames the California Department of Health Services (CDHS) as the California Department of Health Care Services (DHCS). Contracts resulting from this procurement and approved before July 1, 2007, shall continue in full force and effect, with the renamed DHCS assuming all of the rights, obligations, liabilities, and duties of the former CDHS. Contracts resulting from this procurement and approved on or after July 1, 2007, that refer to CDHS shall be interpreted to refer to the renamed DHCS. DHCS shall assume all of the rights, obligations, liabilities, and duties of the former CDHS.

Attachment 1

DVBE Instructions / Forms

Disabled Veteran Business Enterprise Participation (DVBE) Information

DVBE Definition (for this document only)

- A California firm whose ownership, daily management, and operational controls meets all statutory DVBE certification requirements, as documented by the possession of a certification letter issued by the Department of General Services, Office of Small Business and DVBE Certification [OSDC] (hereafter referred to as DGS).

California Requirements

- The State of California requires a three percent (3%) participation level in state contracts to further disabled veteran business enterprise (DVBE) participation in California.
- Only DVBEs, possessing a current DVBE certification issued by DGS, may be claimed for participation. Over 600 DVBE firms are presently certified.
- Effective January 1, 2004, legislation was enacted to require all small business, microbusinesses, and disabled veteran business enterprises to perform a "commercially useful function" in any contract they perform for the State.

  A business that is performing a commercially useful function is one that does all of the following:

  1. Is responsible for the execution of a distinct element of the work of the contract.
  2. Carries out its obligation by actually performing, managing or supervising the work involved.
  3. Performs work that is normal for its business, services and function.
  4. Is not further subcontracting a portion of the work that is greater than that expected to be subcontracted by normal industry practices.

CDHS Rights / Requirements

- Unless DVBE participation is exempted by the California Department of Health Services (CDHS), a 3% DVBE participation level is required for all service contracts with a total value of $10,000 or more.
- CDHS reserves the right to exempt any contract from DVBE participation when it is determined to be in the Department's best interest to do so.
- CDHS reserves the right to waive DVBE participation requirements at any time prior to the bid/proposal submission deadline. Said waivers may be announced by way of a faxed or written correction notice, administrative bulletin, or bid document addendum.

For answers or help, dial:

(916) 650-0205

- CDHS reserves the right to waive "Good Faith Effort" advertising when CDHS believes that bidding time lines do not permit sufficient advertising.
- CDHS reserves the right to contact bidders/proposers during the bidding/evaluation process to collect clarifying information or to request corrections, as necessary, to DVBE documentation.
- **The accompanying instructions must be strictly followed.** Failure to do so may be grounds for bid/proposal disqualification.

Dial (916) 650-0205, if you have a question or need help.

Participation Requirements of this Solicitation

- Each prime contractor must either achieve 3% DVBE participation **or** demonstrate that an adequate "Good Faith Effort" (GFE) was made to achieve DVBE participation.
- Firms submitting bid responses with either less than 3% DVBE participation **and/or** a less than adequate GFE, will be deemed nonresponsive and ineligible to receive a contract award.

DVBE Instructions

How to Calculate 3% Participation

Unless instructed otherwise in the bid document, first determine the total dollar value/amount that will be bid, then multiply this figure by 3% to determine how much of the contract budget should be spent on DVBE supplied services, labor, supplies, materials, or equipment.

How to Meet Participation Requirements

1. ***If the prime contractor IS a DVBE***, commit to use your own workforce alone or in combination with other DVBEs to perform commercially useful functions equal to no less than 3% of the contract bid amount. If this fits your firm's situation, do the following:

   Go to page 5. On the form entitled **"Actual DVBE Participation"**, list your firm's name, the name of other participating DVBEs, complete all items, and attach a copy of the DVBE certification issued by DGS to your firm and all other participating DVBE firms.

   OR

2. ***If the prime contractor IS NOT a DVBE***, it must commit to use or subcontract out an amount equal to 3% of the total contract bid amount to qualified DVBE service providers and/or suppliers that will perform a commercially useful function. If this fits your firm's situation, do the following:

   Start right away, do not delay.

   Go to page 5. On the form entitled "**Actual DVBE Participation**", list each proposed subcontracted DVBE, complete all items, and attach a copy of each subcontracted firm's current DGS issued DVBE certification.

   OR

3. ***If the prime contractor IS NOT a DVBE***, *and the bid document is solely soliciting electronic data processing (EDP), information technology (IT), and/or telecommunications services, goods, supplies, equipment, and/or EDP and/or telecommunications services*, do the following:

   Submit a copy of your firm's "Notice of Approved DVBE Business Utilization Plan" issued by DGS' Procurement Division (PD).

   Business Utilization Plans, when allowed, must be submitted to DGS' (PD) prior to the bid/proposal submission deadline and must be subsequently approved. Business Utilization Plans may not be submitted in lieu of actual DVBE participation or in lieu of performing the DVBE good faith effort process for construction or non-EDP or non-IT service contracts.

   Obtain instructions and information about Business Utilization Plans from:

   Department of General Services – Procurement Division
   Small Business and DVBE Services Branch
   707 Third Street, 1st Floor, Room 400
   West Sacramento, CA 95605

   or by calling:

   DGS' Receptionist at (800) 559-5529 or (916) 375-4940

   or by visiting this DGS website: http://www.pd.dgs.ca.gov/publications/utilization.htm

   OR

4. ***Conduct all five (5) steps of the "Good Faith Effort (GFE)"*** process to show what efforts were made to achieve DVBE participation. If your firm is not a certified DVBE or your firm cannot achieve a full 3% DVBE participation level of the total contract bid amount, do the following:

   Go to page 3. Follow the instructions for each of the 5 good faith effort steps. Document your firm's GFE efforts on the form entitled "**Good Faith Effort**" appearing on pages 6 & 7.

DVBE Instructions

GFE Steps / Instructions

Document your GFE efforts on the form in this package entitled "Good Faith Effort".

Do not delay until the final days before your bid is due to start this process.

These five steps may require 4 weeks or more to complete.

1. Dial (916) 650-0205, the CDHS Contract Management Unit voice mail telephone line, to obtain:

a. A referral to another state agency that provides a list of DVBE firms, publication resources, or other information.
b. Assistance in completing the DVBE forms in this package.
c. Answers to questions about DVBE participation and/or GFE documentation requirements.

2. Contact other state ***AND* federal agencies ***AND*** local DVBE organizations for assistance in identifying potential DVBE service providers or suppliers.**

a. Contact one or more California state agencies. DGS' Office of Small Business and DVBE Certification (OSDC) qualifies as one of these contacts. Dial a DGS' operator at (800) 559-5529 or (916) 375-4940; or call DGS' 24-hour telephone recording line at (916) 322-5060. Visit http://www.pd.dgs.ca.gov/publications/resources.htm to obtain the current DVBE Resource Packet. To download a complete list of all certified DVBE firms, visit: http://www.pd.dgs.ca.gov/smbus/sbdvbelist.htm.
b. Contact one or more local California DVBE organizations listed in the DVBE Resource Packet.
c. Contact the Department of Defense Central Contractor Registration (CCR) for a listing of potential DVBEs via the following Internet site: http://www.ccr.gov/. The SBA will not accept telephone inquiries. Before using a DVBE firm referred by the Federal SBA to meet goal participation, verify the named DVBE is registered with DGS as a certified California DVBE.
d. Enter on the form entitled "**Good Faith Effort**": Date/time of contact; name of organization contacted; contact method; and telephone number, email, or Internet address. Print out and attach a copy of each Internet website page visited (e.g., DGS' OSDC and federal SBA) to prove contacts made via the Internet.

3. Unless GFE advertising is waived by CDHS due to time constraints, advertisements for DVBE service providers, subcontractors or suppliers must be placed in at least:

a. One "trade" publication related to a trade or industry, **and**
b. One "focus" publication whose ads are specifically distributed and focused to reach DVBE firms, **or**
c. A single publication that qualifies as both a "trade" and "focus" publication. See DGS' DVBE Resource Packet for a listing of applicable publications.
   1) Ad placement may be specifically directed to publications that distribute their ads to businesses in the geographical areas where the work will be performed.
   2) ***Ads should appear in publications 10–14 calendar days*** prior to the date your bid or proposal response is due to be submitted to CDHS. Ads for CDHS procurements do not need to be publicized for any specific length of time.
   3) Give potential subcontractors/suppliers ample time (i.e., no less than 3-5 working days) to respond to the ad(s), while allowing sufficient time to seriously consider each firm that submits a response.
   4) ***Ads should contain*** information similar to the following:

[Enter your company name]
Is seeking qualified DVBE vendors to provide
[Enter description/list of services/supplies, etc.]
in **[Enter geographical service areas/locations, if applicable]**
for CDHS IFB/RFP **[Enter CDHS IFB/RFP number and/or Project Name]**
Contact: **[Enter a name, address, telephone and fax number, and/or email ID]**
Submit qualifications by: **[date/time]** ***or***
Submit bids by: **[date/time]**

   5) Ads placed in general circulation newspapers including the *LA Times* or the *Sacramento Bee* are not acceptable.

(Continued on next page)

DVBE Instructions

GFE Steps / Instructions (continued)

6) If GFE advertising was not waived by CDHS, attach to the form entitled **"Good Faith Effort"** appearing on pages 6–7, either a copy of the placed ad(s) or a written description citing the exact wording of the ad(s). Indicate, in Step 3 on the Good Faith Effort form, the publication date, whether the publication is a trade publication, focus publication, or both, and whether an ad copy or written ad content is attached.

Document your GFE efforts on the form in this package entitled "Good Faith Effort".

4. Transmit direct solicitations or invitations to bid to potential DVBEs, identified in Steps 2 and/or 3, by way of mail, telephone, email, fax, or other method.

a. At a minimum, submit a ***single sample*** *of one direct solicitation*.

b. If contact with DVBE firms was by telephone, document in writing the conversation, date of contact, person contacted, and business opportunities discussed.

c. Submit a list of the DVBE firms to whom your firm transmitted direct solicitations (i.e., DVBE bidders list). Include each DVBE firm's name, mailing address, telephone number, and email address.

Do not delay until the final days before your bid is due to start this process.

5. Show that the interested DVBE firms that responded to your ad(s) and/or direct solicitations were considered. Bidding firms are strongly encouraged to achieve full or partial DVBE participation, when performing the GFE process.

a. List each DVBE firm that responded to your ad(s), telephone/fax/email contacts, or direct solicitations, if any. If no responses were received, indicate "none", as instructed in Step 5 on page 7.

b. **For each DVBE listed in Step 5 on page 7, indicate if your firm:**

These five steps may require 4 or more weeks to complete.

1) ***WILL USE*** the DVBE to perform a commercially useful function for a specific percentage amount of your bid. For each firm that will be used, do the following:

Enter the name of these DVBEs on the form entitled **"Actual DVBE Participation"**. Indicate whom the DVBE will contract with, the commercially useful function the DVBE will provide or perform, the claimed percentage of use, and the contracting tier. Attach, to Page 5, a copy of the DVBE's current certification issued by DGS.

Participation and GFE forms appear in the pages that follow.

2) ***WILL NOT USE*** the DVBE after giving consideration to such things as the DVBE's qualifications, availability when needed, capacity to perform/deliver, location or proximity to the service area, results of reference checks, and/or the nature of the services offered by the DVBE or the nature of the goods that can be supplied by the DVBE, etc.

For each DVBE firm that will not be used, indicate, in Step 5 on page 7, the business reason(s) for choosing not to use the DVBE.

Use of Proposed DVBEs

If awarded the contract, the Contractor must faithfully use each DVBE proposed for use and listed on the form entitled **"Actual DVBE Participation"**. Exceptions are only allowed if the Contractor submits a Request for Substitution to the Contract Manager of the CDHS funding Program and that request is subsequently approved by CDHS.

Substitution request submission instructions appear in the "Special Terms and Conditions" exhibit clause entitled "Use of Disabled Veteran Business Enterprises". A copy of this exhibit is attached to the bid document and/or will be attached to the resulting contract.

Actual DVBE Participation

NAME OF DVBE FIRM PROPOSED FOR USE (Prime is to enter its own name, if the Prime is a certified DVBE)	**FIRM THAT DVBE WILL CONTRACT WITH** (Prime is to enter "Self", if the Prime is a certified DVBE)	**COMMERCIALLY USEFUL FUNCTION TO BE PERFORMED OR PROVIDED BY A DVBE**	**DVBE % Claimed**	**TIER** (See legend below)

DVBE % Claimed:

Enter the percentage level of actual DVBE participation met, regardless of whether or not the participation achieved equals a full three percent (3%) of the total bid amount. ***Participation may be expressed as a partial/fractional decimal percentage*****. Do not enter dollar figures in the "DVBE % Claimed" column**. The budget sheets, if required, that are submitted in your proposal when responding to an RFP should include the DVBE service providers identified above, unless the bidding firm is uncertain of the budget period in which the DVBE will be used.

TIER = **0 =** Prime Contractor **1 =** Subcontractor/Supplier to the Prime **2 =** Subcontractor/Supplier to Level 1
3 = Subcontractor/Supplier to Level 2, etc.

Attach to this form, a copy of the current DVBE certification issued by DGS for each DVBE listed in the first column. If a new or renewed certification request was recently approved by DGS, but confirmation of DVBE certification has not yet been received, place a footnote next to the DVBE's name and indicate on this form "DVBE Cert Pending" or "DVBE Cert to Follow".

Unless specifically indicated in the bid document, CDHS will not accept state or federal business utilization plans in lieu of meeting DVBE participation and/or GFE requirements when CDHS is solicits bids/proposals from firms to perform non-IT services.

This form may be photocopied or reproduced in a like form for inclusion in a bid response. Bidding firms that choose to render a like copy of this form by computer or other means are advised to omit pages 1–4 that contain instructions.

Please do not return or include in the bid response, a copy of the DVBE instructions preceding this form.

Bidding/Proposing Firm's Name	**Signature**
Printed Name/Title of Person Signing Above	Date Signed

Good Faith Effort

Steps 1 and 2

Show the date and method of contact with CDHS ***and*** show the contacts made with one or more other California state agencies ***and*** the Federal SBA ***and*** one or more California local DVBE organizations (see DGS' Resource Packet).

DATE OF CONTACT	TIME OF CONTACT	NAME OF AGENCY OR ORGANIZATION CONTACTED	CONTACT METHOD (Enter voice mail, internet access, or name of person contacted)	PHONE NUMBER, E-MAIL, OR WWW ADDRESS
		California Department of Health Services		(916) 650-0205
		Dept. of General Services' Small Business and DVBE Certification	Voice mail	(916) 375-4940 or (800) 559-5529
		Dept. of General Services' Small Business and DVBE Certification	Internet access **	http://www.pd.dgs.ca.gov/smbus/contact.htm
		Dept. of Defense Central Contractor Registration (CCR)	Internet access only **	http://www.ccr.gov
			** **Attach one copy of each Internet website page that you visit as proof of this portion of your good faith effort.**	

Step 3

Show proof of advertising in one trade and one DVBE focus publication, ***OR*** one publication qualifying as both a trade and a DVBE focus publication. Be certain to attach the appropriate ad copies or other cited documentation.

NAME OF PUBLICATION SOURCE	PUBLICATION DATE(S)	TYPE OF PUBLICATION Check the one that applies.			COPY OF AD ATTACHED	AD CONTENT ATTACHED
		Trade	Focus	Both	Check the one that applies.	

Step 4

Show proof that direct invitations to bid were transmitted to potential DVBEs by way of mail, telephone, personal e-mail, fax, or other method.

A. At a minimum attach, to this form, at least one **single sample** of an invitation to bid or solicitation that was transmitted directly to potential DVBEs. You may attach:

- One copy of a letter used to solicit bids from potential DVBEs, **or**
- One copy of the narrative content of an emailed or faxed invitation to bid sent to potential DVBEs, **or**
- A full description of the verbal dialog with a potential DVBE via telephone or personal meeting, including date of contact, person spoken to, and potential business opportunities discussed.

B. Attach to this form a copy of the DVBE bidder list. This is the list of certified DVBE firms to whom direct solicitations or invitations to bid were transmitted.

- Include each certified DVBE firm's name, mailing address, email address, telephone and fax number.

(Continued on the next page)

Good Faith Effort (Continued)

Step 5

Show that your firm has considered the interested DVBE firms that responded to your firm's ad(s), personal contacts, and/or direct solicitations. If no responses were received from DVBEs, indicate "None" on the first line of Column 1.

NAME OF DVBE(S) THAT RESPONDED (This column is self-explanatory)	**INDICATE YOUR PROPOSED USE OF EACH DVBE** (Complete the appropriate column below and show percentage use, if applicable)		**REASON(S) FOR NOT CHOOSING TO USE THIS DVBE** (Enter a business reason for not selecting each firm identified in Column 2B)
	COLUMN 2A	**COLUMN 2B**	
COLUMN 1	**Will Use __ Percent**	**X = Will Not Use**	**COLUMN 3**
	%		
	%		
	%		
	%		
	%		
	%		
	%		
	%		
	%		
	%		
	%		

Completion Instructions

For each entry in Column 2A, transfer the firm's name and claimed percentage value to the form entitled **"Actual DVBE Participation"**. Complete Column 2A, only for those DVBEs that your firm fully intends to use. An entry in Column 2A will impose an obligation on your firm to use the DVBE firm shown for the percentage value claimed. ***Participation may be expressed as a partial/fractional decimal percentage.***

Place an "X" in Column 2B for each interested DVBE that your firm does not intend to use.

Complete Column 3 for each "X" placed in Column 2B. In Column 3, indicate the business reason(s) for not selecting the DVBE firm.

If This form may be photocopied or reproduced in a like form for inclusion in a bid response. Bidding firms that choose to render a like copy of this form by computer or other means are advised to omit pages 1–6 that contain instructions.

Sole authority rests with CDHS to determine whether or not a bidder/proposer has successfully documented actual DVBE participation and/or whether a bidder/proposer has made an adequate GFE to achieve participation. Bidders/proposers may, at their sole option, choose to submit both forms in this package (documenting both full participation and a GFE) as insurance against a finding that the actual participation claimed is unacceptable.

Should a bidder/proposer choose to do so, it may fax its proposed DVBE participation and/or Good Faith Effort forms to CDHS at (916) 650-0110 for a preliminary acceptance review, prior to submitting these forms in a bid/proposal response. Do not transmit any other bid response materials to this telephone number. CDHS will attempt to complete a preliminary DVBE acceptance review within three (3) working days following the date of receipt.

Bidding/Proposing Firm's Name	**Signature**
Printed Name/Title of Person Signing Above	Date Signed

MODEL MIS GUIDELINES

The Applicant's MIS must provide support for all functions of the Plan's processes and procedures related to the flow and use of data within the Plan and have the capability to capture and utilize various data elements for Plan administration and management purposes.

Seven conceptual subsystems are used in the Model MIS Requirements to identify specific functions and capabilities of a Plan's MIS. These subsystems focus on the individual system functions or capabilities which provide support for the following areas:

Administration/Planning
Financial
Enrollee/Eligibility
Provider
Encounter/Claims Processing
Utilization/Quality Improvement/Assurance
Reporting

The following is a list of those functions which have not been identified in one of the seven subsystems:

SYSTEM WIDE FUNCTIONS

Functions and Capabilities

Systemwide conditions will include:

1. On-line inquiry access by the contractor for enrollee and provider eligibility information/verification.

2. On-line read-only access by the Department to the contractor's MIS.

3. Provisions for updating and edit processes for all information entered with history of adjustments and audit trail(s) for both current and retroactive data. Monitor errors incurred during update/edit by type of error, frequency and documentation of correction.

4. Supports use of a variety of inputs, including manual, electronic transmission, or other means.

5. Archiving data and backup/restore procedures in the event of system failure.

6. Linkages among all MIS subsystems either automated or manual. (See Administration Subsystem, Financial Subsystem, Enrollee /Eligibility Subsystem, Provider Subsystem, Encounter/Claims Processing Subsystem, Quality Management/Quality Assurance/Utilization Review Subsystem).

7. Interrelate enrollee/provider data with utilization and accounting data.

The seven subsystems consist of the following:

ADMINISTRATION SUBSYSTEM

The administration subsystem supports the day-to-day management of the major plan functions -- financial, enrollment, disenrollment, encounter data recording, claims payment/processing, service utilization, quality assurance, provider contracts, and other administrative and managerial functions. This subsystem also supports long-term strategic planning.

The Administration subsystem will have the capability to:

Integrate data from all subsystems/modules that constitute the Contractor's MIS.

FINANCIAL SUBSYSTEM

The financial subsystem should provide the necessary data for all accounting functions including cost accounting, inventory, fixed assets, payroll, general ledger, and financial statement presentation. The financial subsystem should provide management with information that can demonstrate that the proposed or existing health plan is meeting, exceeding, or falling short of fiscal goals. The information should provide management with the necessary tools to spot the early signs of fiscal distress, allowing management to take corrective action where appropriate.

Functions and Capabilities

The Financial subsystem will have the capability to:

1. Provide information relative to a Health Plan's economic resources, the claims to those resources (obligations), and the effects of transactions, events, and circumstances that change resources and claims to resources.

2. Provide relevant information. Information is relevant if it provides knowledge concerning past events (feedback value) or future events (predictive value).

3. Produce financial statements in conformity with Generally Accepted Accounting Principles.

ENROLLEE/ELIGIBILITY SUBSYSTEM

The enrollee/eligibility subsystem collects, processes, and maintains current and historical information on enrollee(s), enrollee groups, or other plan entities.

Functions and Capabilities

The Enrollee/Eligibility subsystem will have the capability to:

1. Identify other health coverage available or third party liability (TPL).

2. Identify and monitors enrollee needs (i.e. language preference or lack of transportation, etc).

3. Maintain history files.

4. Maintain information on enrollee disenrollments, complaint/grievance activities, including reason or type of disenrollment, complaint or grievance, and resolution by incidence.

5. Translate or edit data received prior to inclusion into Plan's MIS.

6. Provide error reports and a reconciliation process between new data and data existing in MIS.

7. Identify disenrollments by provider.

8. Provide enrollees timely information regarding plan benefits, sites, and any other required information.

9. Monitor PCP capacity and limitations prior to linkage of enrollee to PCP.

10. Assign enrollee to PCP if no choice is made by enrollee.

11. Verify enrollee eligibility for medical services rendered or for other enrollee inquires.

12. Assign each enrollee a unique identification number.

13. Access/search records by a variety of fields (e.g. name, unique identification numbers, date of birth, zip, SSN etc.) for eligibility verification.

PROVIDER SUBSYSTEM

The provider subsystem collects, processes, and maintains current and historical data on program providers, including services, payment methodology, license information, service capacity, and facility linkages.

Functions and Capabilities

The Provider subsystem will have the capability to:

1. Identify specialty(ies), admission privileges, enrollee linkage, capacity, emergency arrangements or contact, and other limitations or restrictions.

2. Maintain provider history files.

3. Maintain provider fee schedules/remuneration agreements.

4. Support Plan credentialing, re-credentialing, and credential tracking processes; incorporates or links information to provider record.

5. Support monitoring activity for physician to enrollee ratios (actual to maximum) and total provider enrollment to physician and plan capacity.

6. Edit for duplicate assignment of enrollee to provider.

7. Monitor and track provider/enrollee complaints grievances/appeals from receipt to disposition or resolution by provider.

8. Flag and identify provider with restrictive conditions.

ENCOUNTER/CLAIMS PROCESSING SUBSYSTEM

The encounter/claims processing subsystem collects, processes, and stores data on all health services delivered for which the plan is responsible. The functions of this subsystem are claims payment processing and capturing medical service utilization data. The subsystem captures all medically related service, including drug or medical supplies, using standard codes (e.g. CPT-4, HCPCS, ICD9-CM, UB92 Revenue Codes) rendered by medical providers to an eligible plan enrollee regardless of re-numeration arrangement (e.g. capitation/fee-for-service). It approves, prepares for payment, or may return or deny claims submitted. This subsystem may integrate manual and automated systems to validate and adjudicate claims and encounters.

Functions and Capabilities

The Encounter/Claims Processing subsystem will have the capability to:

1. Accommodate various input methods - electronic submission, tape, claim document, magnetic media.

2. Support entry of a minimum of two diagnosis codes for each service line entry as required by the service rendered.

3. Edit and audit to ensure allowed services are provided by eligible providers for eligible recipients.

4. Interface with enrollee and provider files.

5. Identify and report TPL potential.

6. Edit for utilization and service criteria, medical policy, fee schedules.

7. Submit data to the State through electronic transmission.

8. Support multiple fee schedules for individual providers, groups etc.

9. Provide timely, accurate, and complete data for monitoring claims processing performance, utilization.

10. Maintain and apply prepayment edits to verify accuracy and validity of claims data for proper adjudication.

11. Maintain and apply edits and audits to verify timely, accurate, and complete encounter data reporting.

12. Submit encounter data to the California Department of Health Services (CDHS) on a monthly basis.

13. Submit all encounter data within 90 days following the end of the reporting month in which the encounter occurred to the CDHS.

14. To provide reimbursement to non-contracted providers for emergency services rendered to enrollees in a timely fashion.

QUALITY MANAGEMENT/QUALITY ASSURANCE/UTILIZATION SUBSYSTEM

The quality management/quality assurance/utilization review subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of quality of care given, detection of over and under utilization, and the development of user defined criteria and standards. These reports profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals.

The subsystem supports tracking utilization control function(s) and monitoring activities for inpatient admissions, emergency room use, ancillary, and out-of-area services. It provides profiles, occurrence reporting, monitoring and evaluation studies, and enrollee satisfaction survey compilations. The subsystem may integrate plan's manual and automated processes or incorporate other software reporting and/or analysis programs.

The subsystem incorporates and summarizes information from enrollee surveys, provider and enrollee complaints, and grievance/ appeal processes.

Functions and Capabilities

The Quality Management/Quality Assurance/Utilization Review subsystem will have the capability to:

1. Develop and establishment Plan performance measurement standards.

2. Support Plan processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provides feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement).

3. Support development of cost and utilization reports by provider and service.

4. Provide aggregate performance measures using standardized quality indicators similar to Health Plan Employer Data and Information Set (HEDIS).

5. Support the management of referral/utilization control processes and procedures.

6. Edit referral-utilization control data for completeness and accuracy.

7. Support functions of reviewing access, use and coordination of services (i.e. track prescription drug utilization; actions of Peer Review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit.).

8. Store patient satisfaction data through use of enrollee surveys, grievance, complaint/appeals processes etc.

REPORTING SUBSYSTEM

The reporting subsystem supports reporting requirements for the health plan management and CDHS of all plan operations. It allows the health plan to develop various reports to enable plan management and CDHS to make intelligent decisions regarding health plan activity.

Functions and Capabilities

The Reporting subsystem will have the capability to:

1. Produce all standard, Department-defined and ad hoc reports from the data available in all MIS subsystems. Reporting media for encounter data will consist of telecommunication, diskette or tape. All other reports will be submitted both on hard copy and diskette in ASCII format unless otherwise agreed between the Contractor and the Department (see Exhibit A, Attachment 3 Management Information Systems of the Geographic Managed Care boilerplate contract for a complete description of Department data and reporting requirements).

2. Adjust to flexible reporting periods to permit the development of reports at irregular periods as needed.

3. Generate reports which provide unduplicated counts of enrollees, providers, payments and units of service unless otherwise specified.

B. Health Services Delivery Measures

Health delivery measures must not only identify that an event has occurred, but also identify why a particular event or trend is occurring. There are certain measures that allow a health plan to identify and assess deviations (positive or negative) in the delivery of health care. The following list is not meant to encompass all the performance measures that should be routinely available to HMO managers, but is designed to provide many of the common and most critical measurement tools. The following list identifies commonly used indicators:

1. Inpatient bed days: All actual utilization should be reported for actual, expected (i.e. anticipated or budgeted) and the variance for the current period and year-to-date. It should be reported in days, days per 1,000 members, and as a percentage for the following categories:

Total inpatient days:

* Inpatient days by hospital and by service (e.g. orthopaedics)
* Inpatient days by admitting physician and by Primary Care Physician (PCP)
* Inpatient days by age and sex and by group

2. Hospital discharges: All discharges (or admissions) should be reported for actual, expected (i.e., anticipated of budget) and the variance for the current period and year-to-date. They should be reported in discharges, discharges per 1,000 members, and by average length of stay for the following:

Total discharges:

* Discharges by hospital and by service
* Discharges by admitting physician and by PCP
* Discharges by age and sex and group

3. Primary Care Physician Visits: All visits should be reported for actual, expected (i.e., anticipated or budget) and the variance for the current period and year-to-date. They should be reported in the number of visits per member per year for the following:

Total PCP visits:

* PCP visits by PCP
* PCP visits by type (e.g., initial, return)
* PCP visits by age and sex and group

4. Specialist/referrals Visits: All visits should be reported for actual, expected (i.e. anticipated or budget) and the variance for the current period and year-to-date. They should be reported in number of visits and number of visits per member per year for the following:

Total Specialist visits:

* Specialist visits by PCP
* Specialist visits by type (e.g., initial, return) and by service (e.g. neurology)
* Specialist visits by age and sex and group

5. Other Medical Services: All visits should be reported for actual, expected (i.e., anticipated or budget) and the variance for the current period and year-to-date. They should be reported in number of visits and number of visits per member per year for the following:

Other Medical Service Visits:

* Visits by PCP
* Visits by service (e.g., X-ray)

* Visits by age and sex and group

6. Member Clinical History: Ability to report on the performance of individual physicians, especially PCPs, in comparison to their peers (e.g., internists, family practice, etc) and to the expected (i.e., anticipated or budgeted) for a variety of measures:

   a. Financial Measures on a per-member per-month basis:

      * Payments to physicians for capitated services
      * Payments to physicians for non-capitated services
      * Amount withheld on capitated payments
      * Amount withheld on non-capitated payments
      * Claims costs for referral services by PCP and by service
      * Claims costs for hospital services by PCP and by service
      * Claims costs for other medical services by PCP and by service

   b. Utilization measures:

      Inpatient days per 1,000 enrollees by PCP and by service.
      Specialist visits per member per year by PCP and by service.
      Other medical services per member per year by PCP and by service.

   c. Enrollment measures:

      Number of enrollees by PCP and by age, sex, and group.

   d. Enrollment measures: the number of members and contracts should be reported to management on a regular basis for the following categories:

      Total members:

      By age and sex and contract type (family, individual, etc.)

MCO BASELINE ASSESSMENT: INFORMATION SYSTEM CAPABILITIES

I. GENERAL INFORMATION

Please provide the following general information.

A. Managed Care Model Type: (circle one)

HMO-Staff HMO-Group HMO-IPA HMO-Mixed Other:_____

B. Year Incorporated: _____

C. Member Enrollment for Last Three (3) Years:

	2006	**2005**	**2004**
Privately Insured	_____	_____	_____
Medicare	_____	_____	_____
Medicaid	_____	_____	_____
Other	_____	_____	_____

II. DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information and data on ancillary services such as prescription drugs.

Administrative Data (Claims and Encounter Data)

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

1. Do you use standard claims or encounter forms? If so, please specify (e.g., HCFA 1500, UB92).

Hospital: _____
Physician: _____
Drug: _____
Other: _____

2. We would like to understand the means by which claims or encounters are submitted to your plan. We also are interested in an estimate of what percentage (if any) of services provided to your enrollees are <u>not</u> submitted as claims or encounters and therefore are not represented in your administrative data. Please provide the following percentages:

	Claims/Encounter Type				
Medium	Hospital	Physician		Drugs	Other
		PCP	Specialist		
Claims Encounters submitted electronically					
Claims/encounters submitted on paper					
Services not submitted as claims or encounters					
Total	100%	100%	100%	100%	100%

3. Please document whether the following data elements are required for each of the types of claims/encounters identified below. If required, enter an "R" in the appropriate box.

	Claims/Encounter Type				
Data Elements	Hospital	Physician		Drugs	Other
		PCP	Specialist		
Patient Gender					
Patient DOB/Age					
Diagnosis					
Procedure					
First Date of Service					
Last Date of Service					
Revenue Code					
Provider Specialty					

4. How many diagnoses are captured on each claim? On each encounter?

	Claim	Encounter
Institutional Data:	_____	_____
Professional Data:	_____	_____

5. Can you distinguish between principal and secondary diagnoses?

6. System Overview Flowcharts: Please provide a high-level overview of the structure of your management information system(s).

7. Please explain what happens if a claim/encounter is submitted and one or more required fields are missing, incomplete or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-9 code?

Institutional Data:

Professional Data:

8. What steps do you take to verify the accuracy of submitted information e.g., procedure code-diagnosis code edits, gender-diagnosis, gender-procedure code edits)?

Institutional Data:

Professional Data:

9. Under what circumstances can claims processors change claims/encounter information?

10. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's SSN is unknown, do you enter the member's SSN instead?

11. Are claims/encounters received directly from the provider (i.e., hospital, physician, pharmacy) or do they go through an intermediary? If the data are submitted through an intermediary, what changes, if any, are made to the data?

12. Please estimate the percentage of claims/encounters that are coded using the following coding schemes:

Coding Scheme	**Inpatient Diagnosis**	**Inpatient Procedure**	**Ambulatory /Outpatient Diagnosis**	**Ambulatory/ Outpatient procedure**	**Drug Diagnosis**
ICD-9-CM					
CPT-4					
HCPCS					
DSM-IV					
Internally-Developed					
Other (Specify)					
Not Required					
Total	**100%**	**100%**	**100%**	**100%**	**100%**

13. Please describe any recent (i.e., within the last three years) upgrades or consolidations of your information systems.

14. For each Medicaid Health Plan Employer Data & Information Set (HEDIS) measure identified below, please indicate the data source/method you would use:

Medicaid HEDIS Measure	Administrative Data Only	Medical Record Review Only	Hybrid Method
Childhood Immunization Rates			
Well Child Visits			
Adolescent Well care visits			
Substance Abuse Counseling for Adolescents			
Cervical cancer screening			
Low birth weight			
Initiation of Prenatal Care			
Prenatal Care Utilization			
Ambulatory Follow-up after hospitalization for Mental Disorders			
Utilization of PCPs Preventive Services			
Provider Availability (Access)			
Diabetes Monitoring			

B. Enrollment System

1. Please describe any major changes in the enrollment system(s) which could affect the quality or completeness of the enrollment data.

2. How does your plan uniquely identify members?

3. How do you handle member disenrollment and re-enrollment in the same product? Does the member retain the same ID?

C. Ancillary Systems

1. Does your plan incorporate data from vendors to calculate any of the following quality measures? If so, which measures require vendor data?

Measure	**Vendor Name**
Childhood Immunization Rate(s)	
Well Child Visits	
Initiation of Prenatal Care	
Cervical Cancer Screening	
Low Birth weight	
Prenatal Care in First Trimester	
Substance Abuse Counseling for Adolescents	
Glycohemoglobin Monitoring	
Ambulatory Follow-Up After Hospitalization for Specified Mental health disorders	
Provider Certification	

2. Discuss any concerns you may have about the quality or completeness of any vendor data.

III. COMPENSATION STRUCTURE

The purpose of this section is to evaluate the provider compensation structure as this may influence the quality and completeness of data. Please identify the percentage of member months in your plan contributed by members whose primary care providers and specialists are compensated through each of the following payment mechanisms

Payment Mechanism	**Provider Type**	
	PCP	**Specialist**
1. Salaried		
2. Fee-for-Service - no withhold or bonus		
3. Fee-for-Service with withhold % withhold:		
4. Fee-for-service with bonus Bonus range:		
5. Capitated - no withhold or bonus		
6. Capitated with withhold % withhold		
7. Capitated with bonus Bonus range:		
8. Other:		
TOTAL	**100%**	**100%**